

# **Solving the Mystery of the Adult/Adolescent HIV and AIDS Case Report Form**

## **New Highlights**

Clinical Data and Research  
Indiana State Department of Health  
800-376-2501

### **HIV/AIDS Case Report Forms**


**The HIV/AIDS case report forms, both adult and pediatric, began collecting additional information January 1, 2003.**

**Accurate, thorough, case reports provide demographic information regarding the spread of the HIV/AIDS infection.**

**Reporting sex, race, ethnicity, and behavior allows us to gear programs toward specific populations and areas of need.**

**Case reports need to be initiated within 72 hours of receipt of a confirmatory test. All HIV-infected pregnant women must be reported immediately. All babies born to HIV-infected or AIDS-diagnosed mothers must be reported immediately after birth.**

<b>PATIENT INFORMATION</b>		Phone No. : (    )	
Patient's Name (Last, First, M.I.): _____		Zip _____	
Address: _____	City: _____	County: _____	State: _____
Social Security No.: _____		- Patient identifier information is not transmitted to CDC	
RETURN TO STATE/LOCAL HEALTH DEPARTMENT			

- **Use legal names. If known, put maiden names; put aliases in parentheses.**
- **Dept Of Correction (DOC): If inmate, include name and offender number. It is NOT enough to list just the offender number.**
- ** Social Security numbers are used to prevent duplication of patient records and to find deaths, etc.**

<b>DATE FORM COMPLETED:</b>					
Mo.		Day		Yr.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>REPORT SOURCE:</b>				<input type="text"/>	

- **Date the report is completed.**
- **The ISDH completes the report source.**

III. DEMOGRAPHIC INFORMATION						CTR NO. _____	
<b>DIAGNOSTIC STATUS AT REPORT: (check one)</b> <input type="checkbox"/> 1 HIV Infection (not AIDS) <input type="checkbox"/> 2 AIDS		<b>AGE AT DIAGNOSIS:</b> _____ Years	<b>DATE OF BIRTH:</b> Mo. ____ Day ____ Yr. ____	<b>CURRENT STATUS:</b> Alive <input type="checkbox"/> 1 Dead <input type="checkbox"/> 2 Unk. <input type="checkbox"/> 9	<b>DATE OF DEATH:</b> Mo. ____ Day ____ Yr. ____	<b>STATE/TERRITORY OF DEATH:</b> _____	
<b>SEX (all births):</b> <input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	<b>ETHNICITY (select one):</b> <input type="checkbox"/> 1 Hispanic or Latino <input type="checkbox"/> 2 Not Hispanic or Latino <input type="checkbox"/> 9 Unknown	<b>RACE (select one or more):</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Unknown			<b>COUNTRY OF BIRTH:</b> <input type="checkbox"/> 1 U.S. <input type="checkbox"/> 7 U.S. Dependencies and Possessions (incl. Puerto Rico) (specify) _____ <input type="checkbox"/> 8 Other (specify) _____ <input type="checkbox"/> 9 Unk.		
<b>RESIDENCE AT DIAGNOSIS:</b> City: _____ County: _____ State/Country: _____ Zip Code: _____							

• Write CTR lab number in the area to the right of “III. DEMOGRAPHIC INFORMATION”. (This is the same as the OPSCAN number.)

• There are many people with the same first and last names; Date of Birth is used to differentiate cases.

• If aware of a patient’s death, note the date, cause, and state where the person died. (Send a copy of the death certificate, if available.)



• The federal government now requires the separation of ethnicity and race.



• Each reporter is to select one option in the Ethnicity field, and as many as apply in the Race field.

• Complete the Country of Birth; if born outside of the US, write in the country.

<b>RESIDENCE AT DIAGNOSIS:</b>			
City: _____	County: _____	State/Country: _____	Zip Code: _____

• The residence at first diagnosis may not be the patient’s current address – include the county and the state

• If residence was not an Indiana address, the ISDH will contact the other state to determine if the person has already been reported. That person will be reflected in Indiana prevalence.

•Be specific!

•The facility of first diagnosis may be in Indiana or another state

•The facility of first diagnosis may be different from the facility where the form is being completed.

•Facility type “other” could include: ER, coroner, medicine clinic, etc.

**IV. FACILITY OF FIRST DIAGNOSIS**

Facility Name \_\_\_\_\_

City \_\_\_\_\_

State/Country \_\_\_\_\_

FACILITY SETTING (check one)

☐ 1 Public ☐ 2 Private ☐ 3 Federal ☐ 9 Unk.

FACILITY TYPE (check one)

☐ 01 Physician, HMO ☐ 26 Prenatal/OB clinic

☐ 15 Case Management Agency ☐ 30 Correction facility

☐ 20 HRSA Clinic ☐ 31 Hospital, Inpatient

☐ 22 Counseling & Testing Site ☐ 32 Hospital, Outpatient

☐ 24 Drug treatment center ☐ 88 Other (specify): \_\_\_\_\_



**V. PATIENT HISTORY**

AFTER 1977, AND PRECEDING THE FIRST POSITIVE DIAGNOSIS FOR HIV INFECTION OR AIDS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Sex with female .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Injected nonprescription drugs .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received clotting factor for hemophilia/coagulation disorder .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
Specify disorder: <input type="checkbox"/> 1 Factor VIII <input type="checkbox"/> 2 Factor IX <input type="checkbox"/> 8 Other (Specify): _____			
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Bisexual male .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Person with hemophilia/coagulation disorder .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Transfusion recipient with documented HIV infection .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Transplant recipient with documented HIV infection .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Person with AIDS or documented HIV infection, risk not specified .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received transfusion of blood/blood components (other than clotting factor) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
First Mo. <input type="text"/> Yr. <input type="text"/> Last Mo. <input type="text"/> Yr. <input type="text"/>			
• Received transplant of tissue/organs or artificial insemination .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Worked in a health-care or clinical laboratory setting (specify occupation): .....	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

•Patient History is important in determining a person’s probable source of exposure to HIV.

•Many agencies use this information to develop and target and medical social services and prevention programs.

•If not completed or marked “Unk.”, a DIS referral will be made to interview the patient

- If no laboratory data is provided, there must be documentation by a physician.
- A CD4 is not a definitive diagnosis. A positive Western blot or physician diagnosis is needed.
- A CD4 of less than 200 or 14% along with confirmed HIV is definitive for a diagnosis of AIDS

VI. LABORATORY DATA									
1. HIV ANTIBODY TESTS AT DIAGNOSIS:									
(Indicate <u>first</u> test)									
	Pos	Neg	Ind	Not Done	Mo	Yr			
• HIV-1 EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
• HIV-1/HIV-2 combination EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
• HIV-1 Western blot/IFA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
• Other HIV antibody test (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
• HIV-2 EIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
• HIV-2 Western blot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. POSITIVE HIV DETECTION TEST: (Record <u>earliest</u> test)									
• HIV culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mo	Yr			
• HIV antigen test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
• HIV PCR, DNA, or RNA probe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
• Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. IMMUNOLOGIC LAB TESTS:									
AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS									
• CD4 Count	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cells/ $\mu$ L	Mo	Yr		
• CD4 Percent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	%	Mo	Yr		
First <200 $\mu$ L or <14%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mo	Yr		
• CD4 Count	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cells/ $\mu$ L	Mo	Yr		
• CD4 Percent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	%	Mo	Yr		

VII. PHYSICIAN INFORMATION	
Physician's Name: _____ (Last, First, M.I.)	Phone No: ( ) _____ Medical Record No: _____
Hospital/Facility: _____ Completing Form: _____	Phone No: ( ) _____

- Physician identifier information is not transmitted to CDCI -

- The physician's first and last names and phone number are crucial. The phone number is needed to contact the physician quickly for further information or clarification.
- Please include the medical record number if available.
- Hospital/Facility is the place the patient/client is receiving care.
- Person Completing Form requires the first & last names and their phone number in case that person needs to be contacted.

•Information listed here will define an AIDS diagnosis.

•Be sure of the diagnosis and the date of diagnosis.

IX. CLINICAL STATUS				ASYMPTOMATIC (including acute retroviral syndrome and persistent generalized lymphadenopathy)				Mo		Yr		Symptomatic (not AIDS)				Mo		Yr					
CLINICAL RECORD REVIEWED		Yes	No	ENTER DATE PATIENT WAS DIAGNOSED AS																			
		1	0																				
AIDS INDICATOR DISEASES				Initial Diagnosis		Initial Date						AIDS INDICATOR DISEASES				Initial Diagnosis		Initial Date					
				Def	Pres	Mo	Yr					Def	Pres	Mo	Yr								
Candidiasis, bronchi, trachea, or lungs				1	NA							Lymphoma, Burkitt's (or equivalent term)				1	NA						
Candidiasis, esophageal				1	2							Lymphoma, immunoblastic (or equivalent term)				1	NA						
Carcinoma, invasive cervical				1	NA							Lymphoma, primary in brain				1	NA						
Coccidioidomycosis, disseminated or extrapulmonary				1	NA							Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary				1	2						
Cryptococcosis, extrapulmonary				1	NA							M. tuberculosis, pulmonary*				1	2						
Cryptosporidiosis, chronic intestinal (>1 mo. duration)				1	NA							M. tuberculosis, disseminated or extrapulmonary*				1	2						
Cytomegalovirus disease (other than in liver, spleen, or nodes)				1	NA							Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary				1	2						
Cytomegalovirus retinitis (with loss of vision)				1	2							Pneumocystis carinii pneumonia				1	2						
HIV encephalopathy				1	NA							Pneumonia, recurrent, in 12 mo. period				1	2						
Herpes simplex, chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonia or esophagitis				1	NA							Progressive multifocal leukoencephalopathy				1	NA						
Histoplasmosis, disseminated or extra-pulmonary				1	NA							Salmonella septicemia, recurrent				1	NA						
Isosporiasis, chronic intestinal (>1 mo. duration)				1	NA							Toxoplasmosis of brain				1	2						
Kaposi's sarcoma				1	2							Wasting syndrome due to HIV				1	NA						


Def = definitive diagnosis Pres = presumptive diagnosis \*RVCT CASE NO: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

\* If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? 1 Yes 0 No 9 Unknown

#### X. TREATMENT/SERVICES REFERRALS

Has this patient been informed of higher HIV infection? 1 Yes 0 No 9 Unk.		This patient is receiving or has been referred for:	
This patient's partners will be notified about their HIV exposure and counseled by:		• HIV-related medical services 1 Yes 0 No NA Unk 9 • Substance abuse treatment services 1 0 8 9 • Mental health services 1 0 8 9 Specify: _____	
1 Health department 2 Physician/provider 3 Patient 9 Unk.			

•Each patient must be informed of their infection.

 •Mental Health Services may specify bipolar, schizophrenia, paranoia, depression, non-inject drugs, alcohol, suicide

•This information tells us what services are being accessed.

*(Again, if the ISDH cannot determine if a person has been informed of their infection, or if partners have been notified, a DIS referral will be made.)*

- The person providing post-test counseling may not be the person completing the form. The record needs the name and phone number of the person doing the post-test counseling.
- If this section is blank or marked “No” or “Unk”, a DIS referral will be made.
- If unable to verify post-test counseling on patient’s diagnosis since 1997, a DIS referral will be initiated.

XI. Post-Test Counseling				
Has the patient been told not to donate blood, plasma, organs, or other body tissue?	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	<input type="checkbox"/> 9 Unk	Date _____
Has this patient been told of their duty to warn all sex and needle-sharing partners of their HIV status prior to engaging in this behavior?	<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 0 No	<input type="checkbox"/> 9 Unk	Date _____
Name of person that provided post-test counseling _____		Telephone No.: (    ) _____		

XII. For Females Only	
Is the patient currently pregnant? .....	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unknown
Due Date: _____	
Obstetrician/NP/Clinic/Family Doctor: .....	Telephone No.: (    ) _____
Is the above provider aware of her HIV status? .....	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unknown
Has this patient been offered information regarding the use of drugs during pregnancy? .....	<input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 9 Unknown
<input type="checkbox"/> Information offered and patient declined	

**COMPLETE THIS SECTION FOR ALL FEMALES**

- Is patient currently pregnant?
- Date of expected delivery.
- Health care provider’s name and phone number.
- Does health care provider know patients HIV status?
- Offered information regarding use of drugs during pregnancy?

<b>Previous Pregnancies since 1992</b>					
# of Abortions:	_____	Dates	_____	_____	_____
# of Miscarriages:	_____	Dates	_____	_____	_____
# of Stillbirths:	_____	Dates	_____	_____	_____
<b>Live Births</b>					
Name of Child	_____	Date of Birth	_____	Hospital	_____
				City	_____
				State	_____
Name of Child	_____	Date of Birth	_____	Hospital	_____
				City	_____
				State	_____
Name of Child	_____	Date of Birth	_____	Hospital	_____
				City	_____
				State	_____

•Previous Pregnancies since 1992:

•Live Births:

Please list name of child, date of birth, hospital, city, and state.

Helpful comments could include the HIV testing status of each child.

<b>XIII. COINFECTION/PARTNERS/COMMENTS</b>							
<b>COINFECTIONS:</b>		Yes	No	Unk.	Diagnosis Date	Acute	Chronic
Hepatitis B		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease (STD)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Specify STD: _____	
<b>PARTNERS:</b>							
Names of known sex or IV drug using partners (including spouse(s) of last 10 years):							
1.	_____	2.	_____				
3.	_____	4.	_____				

This is a new section.

Co-infections and Partners.



•Co-infections:

Hepatitis B and C

Sexually transmitted disease (STD)

Specify which STD- chlamydia, gonorrhea, syphilis, HPV, herpes, other.

Date of diagnosis is important to care and prevention



•Partners:

Sex partners including spouse(s) of last 10 years

IV drug using partners



## COMMENTS

## **Surveillance Contacts**

*Elkhart, Lake, LaPorte, - Sue Ann Mellon*  
*Porter, Newton, Jasper, (219) 755-3030*  
*St. Joseph or White Counties*

*Marion County - (317) 221-2132*

*All other counties,*  
call ISDH Surveillance toll free (800) 376-2501